Medicare Bundled Payment

Has CMS Locked SNFs Out of A Payment Reform Opportunity? If So, Why?

And How Should SNFs Deal With This Setback?

Elise Smith, LTC Pharmacy News, March 2018

We have addressed many issues in our LTC Pharmacy News regarding the challenges facing SNFs in this increasingly complex health care environment. We have spoken of payment reform specific to SNFs, payment reform encompassing much of post-acute care argued by MedPAC, the development of ACOs, and the relentless march of managed care. According to CMS and MedPAC, the key underlying culprit negating efforts at better quality and cost restraint/reduction has been the fee-for-service (FFS) payment model characteristic of post-acute and other providers. It has long been CMS' position that a FFS payment can result in fragmented care with minimal coordination across providers and health care settings. Payment is seen to reward the quantity of services offered by providers rather than the quality of care furnished.

Now we address another major CMS effort to provide a system that tries to remove the wrong incentives by allocating a single, pre-determined payment amount ("bundle") for an episode of care called bundled payment. The innovation started in 2013 and is still in play but with changes that may perhaps hobble the efforts of SNFs – your clients -- to participate in the innovative systems of the future and mature as major players in health care reform. Nevertheless, some experts see a bright side, as discussed below. It is up to LTC pharmacies to determine how they might help SNFs to meet the challenges.

There are two important themes from our perspective that run through CMS' efforts on bundling innovation: whether the models are voluntary or mandatory and the changing role of post-acute providers. Under the current Administration many mandates that providers and hospitals objected to were canceled, but post-acute providers may not have fared well under BPCI Advanced.

This is the primary issue we address below. We think they did not fare well on the face of BPCI Advanced but hope they may be able to accommodate changes and strategies that will put them in the position of being partners of hospitals and physician groups that may elect to participate in BPCI Advanced.

Bundled Payments for Care Improvement Initiative (BPCI)

The Four Original Voluntary Models

In 2013, the CMS Innovation Center (CMMI) began testing the Bundled Payments for Care Improvement (BPCI) initiative.[1] BPCI focused on generating savings and improving quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and readmissions. The initiative was created as a way to link payments across all healthcare providers delivering care during an episode of care. CMS pointed to research that has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work closely together across all specialties and settings.

There were 4 models testing the effects on Medicare spending and quality of patient care when CMS allocates a single, pre-determined payment amount ("bundle") for an episode of care. The participants gained financially if total spending for an episode was below the pre-determined bundled amount (a target price, generally discounted 1-3% from applicable fee-schedule totals) or conversely incur financial losses if spending exceeded the bundled amount.

The range of potential services included in the bundle (e.g., acute hospital inpatient services, post-acute care) differed across models. These models varied based on scope of services included in the bundle, type of organization that holds the overall risk contract for the episodes (e.g., inpatient hospital or post-acute provider), and payment methodology. In some of the models, providers also had flexibility to choose the length of the episode (30, 60, or 90 days). Currently, BPCI payments were not tied to specific quality metrics. **All four models were voluntary, and in Model 3 SNFs could initiate episodes and take risk for the episode.**

- In **Model 1**, the episode of care was defined as the inpatient stay in the acute care hospital.[2] Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule. The first cohort of Awardees in Model 1 began in April 2013 and concluded on March 31, 2016. The remaining Awardees concluded their participation on December 31, 2016.

- In **Model 2**, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge.[3] Models 2 involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under these retrospective payment models, Medicare continues to make fee-for-service (FFS) payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

- **Model 3**, the episode of care is triggered by an acute care hospital stay but **begins at initiation of post-acute care services** with a SNF nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.[4] **Most importantly**, t**his model enabled post-acute entities such as SNFs to be participating providers holding the risk for the episode.** As with Model 2, Medicare continues to make fee-for-service (FFS) payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price. As of January 1, 2018, BPCI Model 3 has 663 participants in "Phase 2," the risk- bearing phase. [5] Contracts are scheduled to expire on September 2018.

- In **Model 4**, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit "no-pay" claims to Medicare and are paid by the hospital out of the bundled payment.[6]

Two Key Categories of Mandatory Bundles

At the same time as BPCI was getting started two other key model categories were in play: they were both mandatory:

- *Episode Payment Models (EPMs) and the Cardiac Rehabilitation Incentive Payment Model (CR.* The EPMs were scheduled to begin on January 1, 2018. Participation was mandatory.

- *The Comprehensive Care for Joint Replacement (CJR) Model* — This bundled payment model, started in 2016, was designed for episodes of care initiated by a hospital stay for lower extremity joint (hip and/or knee) replacements. This model was similar to BPCI Model 2, but a key difference was that ***for most hospitals in the 67 selected geographic areas, participation was <u>mandatory</u> rather than voluntary***. Under the CJR model, about 800 hospitals were to be at financial risk for the care provided during the initial hospital stay plus 90 days after discharge from the hospital. The CJR model began on April 1, 2016 and was currently in its second performance year.

What Happened to the Mandates?

They did not last long. In December 2017, CMS canceled EPMs and the Cardiac Rehabilitation (CR) Incentive Payment Model which had been scheduled to begin on Jan. 1, 2018. In addition, CMS made participation **<u>voluntary</u>** for all hospitals in approximately half of the geographic areas selected for participation in the CJR model (33 of 67 Metropolitan Statistical Areas [MSAs] selected. [7]

These actions must have reflected both very strong provider pushback against mandates and the impact of the anti-regulatory environment of the current Administration. In the final rule addressing the fate of these models, CMS noted that the reevaluation of policies and programs, as well as revised rulemaking, are within an agency's discretion, especially after a change in Administration. The agency did have such discretion but the iterated reasons for its action seemed strained. [8]

<u>BPCI Advanced -- Voluntary</u>

SNFs and other post-acute providers were relieved at the reduction in the number of elimination of much of the mandated models. However, consternation set in again when CMS unveiled BPCI Advanced and did not provide post-acute providers with the ability to initiate an episode and individually undertake a bundle. In short, they cannot play the role that they had played under BPCI Model 3.

On January 9, 2018, CMS released a Request for Applications (RFA) for BPCI Advanced which CMS refers to as the next generation.[9] As described in the RFA, the Innovation Center "will test an alternative voluntary payment model to incentivize financial accountability, care redesign, data analysis and feedback, provider engagement, and patient engagement through the use of bundled payments, care redesign activities, and accountability for performance on quality measures." [10] The huge disappointment was that post-acute providers can only participate though financial partnerships with other providers.

BPCI-Advanced, which will replace the 4 BPCI models is defined by the following characteristics:[11]

- It is a voluntary model;
- It has a single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration;
- There are 29 inpatient clinical episodes and 3 outpatient clinical episodes; CMS may elect to revise the Clinical Episodes in BPCI Advanced on an annual basis beginning January 1, 2020, which will apply to both new Participants and existing Participants;
- Participants selected to participate in BPCI Advanced beginning on October 1, 2018, must commit to be held accountable for one or more Clinical Episodes and may not add or drop such clinical episodes until January 1, 2020;
- The model qualifies as an Advanced Alternative Payment model (APM);[12]
- Payment is tied to performance on quality measures;
- Preliminary target prices are provided in advance of the first performance period of each model year.
- Applications must be submitted by March 12, 2018. The first cohort of participants will start participation in the Model on October 1, 2018, and the Model Period Performance will run through December 31, 2023. CMS will provide a second application opportunity in January 2020.[13]
- *Post-acute providers cannot be episode initiators. In short, they cannot function as they did under Model 3.[14] Post-acute providers may only bear risk as convener participants*.

Why is There No Version of BPCI-Advanced that Initiates with the Post-Acute Period?

CMS must have received many queries on this issue. CMMI/CMS addressed the question multiple times in a variety of FAQs. For example, in a set of FAQs issued in January 2018, CMS explained the following in Q&A 20:[15]

- During development of the next generation episode payment model, we sought to build upon the successes of the BPCI initiative Models 2 (includes inpatient stay) and 3 (initiates with post-acute services).
- We knew that the next generation episode payment model would require a well-developed risk adjusted prospective pricing mechanism, would be an Advanced APM, and, as such, would require payments be tied to quality.
- We also wanted model pricing to recognize and not penalize the efficiency achievements of current BPCI participants. Incorporating all of this into a pricing approach proved challenging.
- We concentrated our efforts on Clinical Episodes that include the inpatient stay.
- Finally, BPCI evaluation findings (see 3rd annual report) also suggested that in Model 3, there were significant shifts in patient-mix for some of the clinical episodes. Findings raised the possibility that some of these patient-mix shifts may not be adequately captured by the claims data which the risk adjustment will rely on.
- At this time, there are no plans for a model that initiates with delivery of post-acute services. CMMI continues to explore episode payment models for post-acute as well as other Medicare services and is always interested in stakeholder input. We also are interested in a model in the post-acute space that could support the IMPACT Act of 2014 goal of payment reform for post-acute services.

In February, CMS again addressed the issue posed in Q13. Why were post-acute care providers not included on the list of eligible Non-Convener Participants? [16] CMS' answer was:

- For BPCI Advanced, Non-Convener Participants must be an Episode Initiator and bear full risk on behalf of itself. To be an Episode Initiator under BPCI Advanced, the Participant must be able to initiate a Clinical Episode. Clinical Episodes in BPCI Advanced are initiated on the first day of an Anchor Stay (for inpatient Clinical Episodes) or an Anchor Procedure (for outpatient Clinical Episodes).

- Since Post-Acute Care providers cannot submit a claim for an Anchor Stay or Anchor Procedure, as those terms are defined for purposes of BPCI Advanced, they are precluded from being a Non-Convener Participant in BPCI Advanced.

The CMS responses seem circular. It appears that post-acute care providers as true participants did not fit into the conditions that CMS set for itself – in particular the need to provide an Advanced APM to satisfy a legislative mandate regarding MACRA.[17]

Post-Acute Care: Industry Reaction

LeadingAge, in conjunction with several major post-acute associations submitted comments to CMS on BPCI Advanced. [18] The letter does a very thorough job of analyzing BPCI Advanced, and the problems it poses for post-acute care and the ultimate success of bundled payment.

Specifically, the co-signers were concerned that by minimizing the role of post-acute care (PAC) providers, CMS is missing an opportunity to improve overall care delivery and, potentially, realize efficiencies and cost savings. Further, LeadingAge et al. argued that if the BPCI Advanced model is intended to replace the current BPCI model, eliminating the opportunity for Model 3 – PAC only bundles and only permitting bundles led by hospitals and physician group practices does little to incent changes in hospital costs of care, the highest cost setting.

In addition, LeadingAge argued that BPCI Advanced doesn't promote redesigned care practices beyond changing the PAC settings they choose to discharge patients to, along with their expectations of these PAC providers to change their practices by demanding shorter lengths of stay.

Moreover, offering the option for PAC providers to continue to participate but only as conveners of "upstream" providers fails to recognize the practical reality in the marketplace. For several reasons this is an impractical role for PAC providers. As a Convener Participant, a PAC provider would bear financial risk for the Episode Initiator, which would be an upstream acute care hospital (ACH) or physician group practice (PGP). This would appear to require the PAC Convener to be responsible for all of an ACH or PGP's episodes within a clinical category, including those they discharged to another PAC provider. This scenario would place extraordinary risk on the PAC provider with little say in the discharge location and consequently the services provided at those settings.

The coalition's recommendations addressed the above concerns. They recommended that:

> 1. CMMI issue guidance indicating that all current Model 3 PAC-only bundles will be allowed to extend their BPCI contracts for another 3-5 years and/or until an adequate replacement program is made available;
>
> 2. CMMI commit to amend the BPCI Advanced model to permit PAC providers to be episode initiators and modify additional elements to the program such as CEHRT requirement that would pose unnecessary barriers to entry.
>
> 3. CMMI convene a group of interested PAC and long-term service and support (LTSS) providers and/or their representatives to develop and test additional alternative payment models that allow these providers to lead innovative care models, accept financial risk, and share in financial rewards by leading these efforts. [19]

Health Care Policy Analysts and Consultants

By and large analysts and consultants reached similar conclusions about the drawbacks of BPCI Advanced for post-acute care providers while nevertheless advocating for post-acute-care to find ways to participate and benefit from BPCI Advanced.

Anne Tumlinson, CEO of *Anne Tumlinson Innovations*, argues that SNFs aren't entirely out of the game. Tumlinson's Washington, D.C.-based research and consulting firm advises healthcare providers, payers and investors on post-acute and long-term care delivery and financing. In a guest article for McKnight's,[20] Tumlinson points out that, like the original BPCI, there is nothing in BPCI Advanced design that prevents SNFs from taking episodic risk as a convener. She believes that the convener role would give SNF organizations more control over post-acute patient movement and expand revenue opportunities beyond the Medicare daily rate. It would shift their role from seeking bed volume to managing post-acute care and episodic risk across multiple sites of care. And, if the SNF-convener does it well, it would allow them to keep a larger portion of the savings.

Tumlinson acknowledges that it is natural for SNF operators to view the convener role very skeptically. How could a SNF persuade hospitals and/or physicians to participate as their partner in bundled payment? It would not be easy, but Tumlinson offers several ways to make the case for participation.

- The SNF, as a convener, is taking the risk and offering the hospital and physicians shared savings, and providing physicians relief from various MACRA requirements;
- The SNF, as a convener, will be even more incentivized to improve performance that affects the hospital's value-based care penalties and bonuses;
- The post-acute care providers participating in the bundle will reduce readmissions but also guarantee that any of their discharges that need readmission, will go back to the originating hospital and not to another hospital (called readmission leakage);
- Bundles have the potential to create more alignment between hospitals and physicians they care about; and
- Under a bundle, CMS can waive the 3-day stay requirement, giving hospitals the chance to reduce costs for certain DRGs and for SNFs to get patients sooner.

Becoming a convener requires scale that many SNF operators don't have. According to Tumlinson, one approach to these challenges is to form **convener organizations** together with other SNF operators. There is precedent for SNFs working collaboratively to take risk. Nursing facility operators in Alabama are doing it through the Medicare Advantage plan they're offering long-stay residents. LeadingAge members in Ohio and Minnesota are doing it to bring scale and expertise to negotiations with managed care organizations.

Perhaps the biggest challenge of all will be a mindset shift from being a facility business that believes strongly in the value of SNF care, to a business that values overall post-acute care efficiency and quality, regardless of where a patient goes. So, to succeed as a convener, SNFs will have to divert some volume from their own buildings to home health. That, she points out, is happening anyway.

Regardless of the challenges, Tumlinson firmly believes that SNF operators need to take every opportunity they can to seek out and manage healthcare risk. It's the only way of guaranteeing a future. “As hard as it sounds, this isn't a time to be cautious. It's a time to step up.”

Meredith Larson, Baker Donelson Bearman Caldwell & Berkowitz PC, also acknowledges the barriers to SNF participation. 21 But she too sees the necessity of SNFs to do what they can to participate lest they fall behind the evolution of emerging quality-oriented models. She comments that despite the limitation on opportunities for direct participation in BPCI Advanced, the updated model does present opportunities for PAC providers. BPCI Advanced allows Participants and Convener Participants to enter into Financial Arrangements to share Net Payment Reconciliation Amounts (NPRAs) with PAC providers (and others) through NPRA Sharing Agreements. However, she adds that admittedly under the current BPCI program, providers have rarely indulged in available gainsharing opportunities and physicians are the most likely to benefit.

She concludes, that regardless of whether a PAC provider decides to act as a Convener Participant or enter into a Financial Arrangement for NPRA sharing, maintaining good relationships with BPCI Advanced Participants will be important to PAC providers. Because achievement of certain quality measures will factor into calculations of NPRAs, PAC providers that are willing to cooperate in quality improvement programs and active care coordination will be preferable partners for Participants. Thus, PAC providers will have an even more prominent role in achieving cost savings goals, even if they are not directly participating in the program.

According to Brian Ellsworth, director of payment transformation at the Minneapolis-based consulting firm Health Dimensions Group, [22] being proactive is one of the best things post-acute providers can do to position themselves for success in the world of Bundled Payments for Care Improvement Advanced (BPCI Advanced), “The ideal scenario is to get a seat at the table right as this program is being designed, right now as the bundlers are completing their application,” he told Maggie Flynn at Skilled Nursing News (SNN). His formula for successful SNF participation includes the following steps.

In the best-case scenario, SNFs and post-acute providers would position themselves to become a risk-sharing partner with bundlers in BPCI Advanced.

- They should be really focused on how they can take risk from the BPCI bundler — either partial or full risk — for the downstream post-acute services, and do so in a way that allows the BPCI Advanced bundler to comfortably take more risk than they might otherwise take;
- SNFs and post-acute providers should be capable of full integration with the bundler's approach to care. They also have to be able to successfully manage lengths of stay for patients and have strong protocols to prevent hospital readmission;
- And depending on how much risk they might be taking post-discharge, they would also potentially need some kind of care management infrastructure for once folks return to the community; and
- An extremely important first step is gaining some market intelligence right now about who's considering BPCI Advanced this in their community — particularly their referring hospitals, but also if any physician groups are considering participation.

One of Ellsworth's recommendations echoes through all of health care – the importance of data to prove value. Ellsworth opines that SNFs and post-acute providers will have to prove their value. Having a proven track record with reduced length of stay, readmission prevention, and discharge management — with data to back it up — is the best-case scenario. Ellsworth said. If this isn't available, SNFs and post-acute providers should have a good explanation of their value, their strategic goals and quality scores. They should also show a willingness to integrate into the bundler's care redesign strategy. .

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[1] CMS.gov Bundled Payment for Care Improvement (BPCI) Initiative: General Information , https://innovation.cms.gov/initiatives/bundled-payments/

[2] CMS.gov BPCI Model 1: Retrospective Acute Care Hospital Stay Only, https://innovation.cms.gov/initiatives/BPCI-Model-1/index.html

[3] CMS.gov, BPCI Model 2: Retrospective Acute & Post Acute Care Episode, https://innovation.cms.gov/initiatives/BPCI-Model-2/index.html

[4] CMS.gov, BPCI Model 3: Retrospective Post Acute Care Only https://innovation.cms.gov/initiatives/BPCI-Model-3/index.html

[5] The 663 participants are comprised of 85 Awardees and 578 Episode Initiators involved in care redesign. For Model 3, "Episode Initiator" means a post-acute care provider or a physician group practice that triggers an episode of care. The breakdown of participants by provider type is as follows: **Skilled Nursing Facilities (540),** Home Health Agencies (58), Inpatient Rehab Facilities (9), Physician Group Practices (41) and Long Term Care Hospitals (0). (Will current BPCI Model 3 providers be allowed to extend their contracts that are scheduled to expire on September 30, 2018?).

[6] CMS.gov, BPCI Model 4: Prospective Acute Care Hospital Stay Only https://innovation.cms.gov/initiatives/BPCI-Model-4/index.html

[7] Medicare Program; Cancellation of Advancing Care Coordination Through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model: Extreme and Uncontrollable Circumstances Policy for the Comprehensive Care for Joint Replacement Payment Model, 82 Federal Register 57066, December 1, 2017.

[8] Ibid on page 57066 "CMS believes that requiring hospitals to participate in additional episode payment models at this time is not in the best interest of the Agency or the affected providers. Many providers are currently engaged in voluntary CMS initiatives, and CMS expects to continue offering initiatives, including episode-based payment models. CMS also believes that reducing the number of providers required to participate in the CJR model will allow the agency to continue to evaluate its effects while limiting the geographic reach of our current mandatory models. CMS also believes that cancelling the EPMs and CR

Incentive Payment Model, as well as altering the scope of the CJR model, offers CMS flexibility to design and test other episode-based payment models while evaluating the ongoing CJR model……"

[9] CMS/CMMI, Patient Care Models Group, Bundled Payments for Care Improvement Advanced, Request for Applications, Last modified: 01-08-2018. https://innovation.cms.gov/Files/x/bpciadvanced-rfa.pdf

[10] Ibid.

[11] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-09.html and https://innovation.cms.gov/Files/x/bpciadvanced-rfa.pdf

[12] Of note, BPCI Advanced will qualify as an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program. In 2015, Congress passed the Medicare Access and Chip Reauthorization Act or MACRA. MACRA requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid in Medicare. Under Advanced APMs, providers take on financial risk to earn the Advanced APM incentive payment. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-09.html

[13] Providers that can participate as a Non-Convener Participant: See Footnotes 9-11.

- Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs)

Entities that can participate as a Convener Participant:

- Eligible entities that are Medicare-enrolled providers or suppliers
- Eligible entities that are not enrolled in Medicare
- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)

[15] https://innovation.cms.gov/Files/x/bpci-advanced-faqs.pdf

[16] https://innovation.cms.gov/Files/x/bpci-advanced-faqs2.pdf

[17] See footnote 12.

[18] AMDA – The Society for Post-Acute and Long-Term Care Medicine, ElevatingHOME, subsidiary organization, VNAA, National Association of Home Care & Hospice, National Association for the Support of Long Term Care (NASL), and Terrence A. O'Malley, M.D.
http://leadingage.org/sites/default/files/Letter%20on%20BPCI%20Advanced%20to%20ABassano%20022818%20FINAL.pdf

[19] Ibid.

[20] Anne Tumlinson, SNFs: Time to Step Up, Not Give Up, https://www.mcknights.com/guest-columns/snfs-time-to-step-up-not-give-up/article/736961

[21] Meredith N. Larson, Baker Donelson Bearman Caldwell & Berkowitz PC, Post-Acute Providers Ponder Role in BPCI Advanced, February 1, 2018, https://www.bakerdonelson.com/post-acute-care-providers-ponder-role-in-bpci-advanced

[22] Maggie Flynn, How Skilled Nursing Facilities Can Control Their Bundled Payment Destiny March 3, 2018, Interview with https://skillednursingnews.com/2018/03/skilled-nursing-facilities-can-control-bundled-payment-destiny/, Brian Ellsworth, director of payment transformation at the Minneapolis-based consulting firm Health Dimensions Group